Seminole County EMS Clinical Assessment Program
Face-to-Face Medical Director Meeting Attendance Record

Name: _____ **Mentor:** _____

Agency: **(CIRCLE ONE)** **CFD** **LFD** **LMFD** **OFD** **SCFD** **SFD**

Call documentation reviewed for the purposes of Paramedic Clinical Assessment Program must be completed by the provisional paramedic

	1ST Meeting	2ND Meeting	3RD Meeting
DATE:			
LOCATION:			
SHIFT:			
# Runs Rev.			
IR#			
IR#			
IR#			
MD's INITIALS			

This form must be signed by the Medical Director and submitted to the records manager prior to provisional release.